February 2002

Update information for the booklet "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services."

Please note, since the printing of this booklet in August 2000, the following changes have been made:

1. The monthly Part B premium is $54 in 2002. This change affects pages 7, 8 and 10. Premium amounts can change each year.

2. Replace the information in the box at the top of page 8 with the following:

   You can not join a Medicare managed care plan or Private Fee-for-Service plan if you have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). People with ESRD who start dialysis and are already in a Medicare managed care plan or Private Fee-for-Service plan can stay in the plan they are in or join another plan offered by the same company in the same state. You must continue to pay the monthly Part B premium of $54 in 2002.

   If you've had a successful kidney transplant, you may be able to join a plan. Call 1-800-MEDICARE (1-800-633-4227) for more information about End-Stage Renal Disease and Medicare health plans.

   If you have ESRD and are in a plan and the plan leaves Medicare or no longer provides coverage in your area, you can join another Medicare managed care plan or Private Fee-for-Service plan if one is available in your area. (This is true for people whose plans left Medicare or stopped providing coverage in their area on or after December 31, 1998.)

3. On page 10, replace the second bullet and the first box with the following information:

   - If you have Part A because of age or disability, but did not take Part B or your Part B coverage was stopped, you can enroll in Part B without paying a higher premium rate if you enroll in Medicare based on End-Stage Renal Disease. Call or visit your local Social Security Office or

call Social Security at 1-800-772-1213 to make an appointment to enroll in Medicare based on End-Stage Renal Disease.

4. On page 34, under "Immunosuppressive drugs," replace the information in parentheses with the following:

   (For information on the length of coverage, see page 35.)

5. On page 35, under "How Long Will Medicare Pay for Transplant Drugs?," remove the answer and replace with the following:

   If you have Medicare only because of kidney failure, Medicare will pay for your immunosuppressive drug therapy for 36 months after the month of the transplant.

   If you already had Medicare because of age or disability before you got ESRD, or if you became eligible for Medicare because of age or disability after receiving a transplant paid for by Medicare, Medicare will continue to pay for your immunosuppressive drugs with no time limit.

6. On page 36, remove the example.

   Under "What if I Can't Pay for the Transplant Drugs?," replace the first sentence with "Transplant drugs can be very costly. If you only have Medicare because of kidney failure, your immunosuppressive drugs are only covered for 36 months after the month of the transplant."

7. On page 37, change the second paragraph (after the two bullets) to read "If you have Medicare only because of kidney failure, and you have the pancreas transplant after the kidney transplant, Medicare will pay for your immunosuppressive drug therapy for 36 months after the month of the pancreas transplant. If you already had Medicare because of age or disability before you got ESRD, or if you became eligible for Medicare because of age or disability after receiving a transplant, Medicare will continue to pay for your immunosuppressive drugs with no time limit."

   The third paragraph regarding diabetes is unchanged.

8. On page 45, the second bullet is changed as follows:

- Have a monthly income of less than $1,273 for a single person or $1,714 for a couple in 2001. These income limits are slightly higher in Hawaii and Alaska.

9. On page 52, amounts below reflect "What YOU pay in 2002 In the Original Medicare Plan."

   For Hospital Stays:

   For each benefit period YOU pay:
   - A total of $812 for a hospital stay of 1-60 days.
   - $203 per day for days 61-90 of a hospital stay.
   - $406 per day for days 91-150 of a hospital stay.
   - All costs for each day beyond 150 days.

   For Skilled Nursing Facility (SNF) Care:
   - Nothing for the first 20 days.
   - Up to $101.50 per day for days 21-100.
   - All costs beyond the 100th day in the benefit period.

10. On page 54, Medicare Part B Covered Preventive Services is changed as shown below:

    Colonoscopy* - Once every 24 months if you are at high risk for colon cancer. If you are not at high risk for colon cancer, once every 10 years, but not within 48 months of a screening flexible sigmoidoscopy.

    Mammogram Screening: Once every 12 months. (You can also get one baseline mammogram between ages 35 and 39.) Medicare also covers new digital technologies for mammogram screening.

    Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every 24 months. Once every 12 months if you are at high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap smear in the past 36 months.

    Shots (vaccinations):
    Flu Shot - Once a year in the fall or winter.

Pneumonia (pneumococcal pneumonia) Shot - One shot may be all you ever need. Ask your doctor.

In the column entitled "Who is covered…," under Diabetes Services, Diabetes self-management training, is changed as shown below:
If requested by your doctor or other provider and you are at risk for complications from diabetes.

Added information:

Important:New Coverage starting January 1,2002!

Glaucoma Screening: Once every 12 months,starting January 1,2002.Must be done or supervised by an eye doctor who is legally allowed to do this service in your state.

Who is covered...
People at high risk for glaucoma,including people with diabetes or a family history of glaucoma.

What YOU pay in the Original Medicare Plan...

20%of the Medicare-approved amount after your yearly Part B deductible.

Medicare Coverage of Kidney Dialysis and Kidney Transplant Service